

§1187.33. Resident data reporting requirements.

(a) To receive payment for nursing facility services, a nursing facility shall meet the following resident data reporting requirements:

(1) The nursing facility shall report individual resident assessment data to the MA Program by submitting, on electronic media by modem transmission as specified by the Department, the Federally approved PA specific MDS in accordance with Departmental requirements.

(i) The data submission for the first calendar quarter of each year shall include assessment data for every MA and every non-MA resident in the nursing facility as of February 1.

(ii) The data submission for the second, third, and fourth quarters of each year shall include assessment data for every MA resident in the nursing facility as of the picture date.

(iii) The data submissions shall include data for any resident admitted on the picture date. The data submission may not include data for a resident discharged on the picture date.

(iv) The data submissions shall include data for an MA resident who was in the nursing facility on the picture date prior to the current picture date and subsequently has been discharged.

(2) The nursing facility shall ensure that the Federally approved PA specific MDS data for each resident accurately describes the resident's condition, as documented in the resident's clinical records maintained by the nursing facility.

(i) The nursing facility's clinical records shall be current, accurate and in sufficient detail to support the reported resident data.

(ii) The Federally approved PA specific MDS shall be coordinated and certified by the nursing facility's RNAC.

(iii) The records listed in this section are subject to periodic verification and audit.

(3) The nursing facility shall maintain the records pertaining to each resident assessment data submission for at least 4 years following the date the nursing facility submits the assessment data to the Department.

(4) The nursing facility shall ensure that assessment data accurately reflect the residents' conditions on the assessment date.

(5) The nursing facility shall submit the assessment data to the Department between the first day of the second month of the quarter and the last day of the second month of the same quarter. The nursing facility shall submit assessment data corrections to the Department in response to edit reports on or before the 15th day of the third month of the quarter. The nursing facility shall submit the signed resident verification report to the Department postmarked no later than 5 business days after the 15th day of the third month of the quarter.

(b) Failure to comply with the submission of resident assessment data.

(1) If a valid assessment is not received within the acceptable time frame for an individual resident, the resident will be assigned the lowest individual RUG-III CMI value for the computation of the facility MA CMI and the highest RUG-III CMI value for the computation of the total facility CMI.

(2) If an error on a classifiable data element on a resident assessment is not corrected by the nursing facility within the specified time frame, the assumed answer for purposes of CMI computations will be "no/not present."

(3) If a valid resident verification report is not received in the time frame outlined in subsection (a)(5), the facility will be assigned the lowest individual RUG-III CMI value for the computation of the facility MA CMI and the highest RUG-III CMI value for the computation of the total facility CMI.

§1187.34. Requirements related to notices and payments pending resident appeals.

(a) The requirements relating to notices authorizing and discontinuing MA payments for nursing facility services are as follows:

(1) *Notices authorizing MA payment.*

(i) The nursing facility shall retain, in its business office, a copy of the Department's notice authorizing MA nursing facility services for each MA conversion resident and for each MA applicant or recipient who is admitted as a resident.

(ii) The Department's notice authorizing MA nursing facility services will specify the effective date of coverage and the amount of money that the resident has available to contribute towards payment. The nursing facility is responsible to obtain the resident's share of the payment.

(2) Notices discontinuing MA payment.

(i) The nursing facility shall retain, in its business office, a copy of the Department's notice discontinuing payment for MA nursing facility services for every resident who the Department determines is no longer eligible to receive MA nursing facility services. The Department's determination may be based upon a review conducted by the Department or the resident's attending physician.

(ii) The Department's notice discontinuing payment for MA nursing facility services will specify the effective date of the discontinuance of coverage, that the resident may appeal the notice within 30 days and that the resident must appeal within 10-calendar days of the date the notice was mailed in order for payments to continue pending the outcome of the hearing on the resident's appeal.

(b) The requirements relating to payments pending resident appeals and recovery of payments subsequent to appeals are as follows:

(1) Payments pending appeal.

(i) If the resident or a representative of the resident appeals the Department's notice discontinuing payment for MA nursing facility services within 10-calendar days of the date on which the notice was mailed to the resident, the Department will continue payments to the nursing facility for nursing facility services rendered to the resident pending the outcome of the hearing on the resident's appeal subject to paragraph (2).

(ii) If the resident or a representative of the resident does not appeal the Department's notice discontinuing payment for MA nursing facility services, or appeals after 10-calendar days from the

date on which the notice was mailed to the resident, the Department will cease payment to the nursing facility for services rendered to the resident beginning on the effective date of the discontinuance of coverage specified in the notice or the date on which the resident was discharged from the facility, whichever date occurs first.

(2) *Payment recovery for services rendered pending appeal.* If a resident's appeal of a notice of discontinuance of payment for MA nursing facility services is denied, the Department will recover payments made to the nursing facility. The period for which the Department will recover payments will begin on the effective date of the discontinuance of coverage specified in the notice to the resident and end on the date on which payments were discontinued as a result of the outcome of the hearing on the resident's appeal or the date of the resident's discharge from the facility, whichever date occurs first.

SUBCHAPTER E. ALLOWABLE PROGRAM COSTS AND POLICIES

§1187.51. Scope.

(a) This subchapter sets forth principles for determining the allowable costs of nursing facilities.

(b) *The Medicare Provider Reimbursement Manual* (HCFA Pub. 15-1) and the Federal regulations at 42 CFR Part 489 (relating to provider and supplier agreements) appropriate to the reimbursement for nursing facility services under the Medicare Program are a supplement to this chapter. If a cost is included in this subchapter as allowable, the HCFA Pub. 15-1 and applicable Federal regulations may be used as a source for more detailed information on that cost. The HCFA Pub. 15-1 and applicable Federal regulations will not be used for a cost that is nonallowable either by a statement to that effect in this chapter or because the cost is not addressed in this chapter or in the MA-11. The HCFA Pub. 15-1 or applicable Federal regulations will not be used to alter the treatment of a cost provided for in this subchapter or the MA-11.

(c) The Department's payment rate for nursing facility services to eligible residents in participating nursing facilities includes allowable costs for routine services. Routine services may include the following:

(1) Regular room, dietary and nursing services, social services and other services required to meet certification standards, medical and surgical supplies and the use of equipment and facilities.

(2) General nursing services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas.

(3) Items furnished routinely and uniformly to residents, such as resident gowns, water pitchers, basins and bedpans.

(4) Items furnished, distributed to residents or used individually by residents in small quantities such as alcohol, applicators, cotton balls, bandaids, antacids, aspirin (and other nonlegend drugs ordinarily kept on hand), suppositories and tongue depressors.

(5) Reusable items furnished to residents, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment and other durable medical equipment.

(6) Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician.

(7) Basic laundry services.

(8) Nonemergency transportation.

(9) Beauty and barber services.

(10) Other special medical services of a rehabilitative, restorative or maintenance nature, designed to restore or maintain the resident's physical and social capacities.

(d) Nursing facilities will receive payment for allowable costs in four general cost centers:

(1) Resident care costs.

(2) Other resident related costs.

(3) Administrative costs.

(4) Capital costs.

(e) Within the limits of this subchapter, allowable costs include those costs necessary to provide nursing facility services. These may include costs related to the following:

(1) *Resident care costs.*

(i) Nursing.

(ii) Director of nursing.

(iii) Related clerical staff.

(iv) Practitioners.

- (v) Medical director.
- (vi) Utilization and medical review.
- (vii) Social services.
- (viii) Resident activities.
- (ix) Volunteer services.
- (x) Over-the-counter drugs.
- (xi) Medical supplies.
- (xii) Physical, occupational and speech therapy.
- (xiii) Oxygen.
- (xiv) Beauty and barber.

(2) *Other resident related costs.*

- (i) Dietary and food.
- (ii) Laundry.
- (iii) Housekeeping.
- (iv) Plant operation and maintenance.

(3) *Administrative costs.*

- (i) Administrator.
- (ii) Office personnel.
- (iii) Management fees.
- (iv) Home office costs.
- (v) Professional services.
- (vi) Determination of eligibility.

- (vii) Advertising.
- (viii) Travel/entertainment.
- (ix) Telephone.
- (x) Insurance.
- (xi) Interest other than that disallowed under §1187.59(a)(24) (relating to nonallowable costs).
- (xii) Legal fees.
- (xiii) Transportation equipment depreciation.
- (xiv) Transportation equipment interest.
- (xv) Amortization - administrative costs.

(4) *Capital costs.*

- (i) Fair rental value.
- (ii) Real estate taxes or reasonable payment made in lieu of real estate taxes.

§1187.52. Allowable cost policies.

(a) The Department will incorporate a nursing facility's direct and indirect allowable costs related to the care of residents into the NIS database. The Department will consider these costs in the setting of prices.

(b) Costs that are not recognized as allowable costs in a fiscal year may not be carried forward or backward to other fiscal years for inclusion in reporting allowable costs. For the cost to be allowable, short-term liabilities shall be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred.

§1187.53. Allocating cost centers.

(a) The nursing facility shall allocate costs between nursing facility and residential in accordance with the allocation bases established by the Department as

contained in this chapter and the MA-11. If the nursing facility has its own more accurate method of allocation, it may be used only if the nursing facility receives written approval from the Department prior to the first day of the applicable cost report year.

(b) The absence of documentation to support allocation or the use of other methods which do not properly reflect use of the Department's required allocation bases or approved changes in bases shall result in disallowances being imposed for each affected line item.

§1187.54. Changes in bed complement during a cost reporting period.

(a) When the nursing facility's bed complement changes during a cost reporting period, the allocation bases are subject to verification at audit.

(b) The nursing facility shall keep adequate documentation of the costs related to bed complement changes during a cost reporting period. The nursing facility shall submit a supplemental Schedule C (computation and allocation of allowable cost), which identifies costs being allocated by the required statistical methods for each period of change.

§1187.55. Selected resident care and other resident related cost policies.

Policies for selected resident care and other resident related costs are as follows:

(1) *Drug services.*

(i) The costs of nonlegend drugs, such as laxatives, aspirin and antacids that are provided directly by a nursing facility from its own supply are allowable costs if the drugs are medically necessary and administered according to a physician's written order or prescription.

(ii) Costs of legend drugs are not allowable costs.

(iii) Costs related to a pharmacy consultant shall be reported as general administrative costs on the cost report.

(2) *Practitioner and therapy services.*

(i) Costs for practitioner and therapy services which are provided on a contract or salary basis by the nursing facility are allowable costs.

(ii) The direct and indirect costs associated with noncompensable cost centers, such as a pharmacy or space rented or used by an independent practitioner, are not allowable costs.

(3) *Volunteer and donated services of individuals.*

(i) The actual costs that a nursing facility incurs when the nursing facility regularly uses the services of volunteer or religious organizations in positions that are normally held by full-time employees who provide resident care or assist with the operation of the nursing facility are allowable costs. The following conditions and limitations apply:

(A) The costs shall be limited to the fair market value of customary compensation of full-time personnel who perform similar services.

(B) The costs shall be based on regular working hours, excluding overtime.

(C) The actual costs for these services shall be supported by substantiating documentation.

(D) The costs will be reimbursed as part of the net operating costs.

(ii) The Department will recognize costs as allowable for nonpaid workers only if the following conditions are met:

(A) The nonpaid workers shall be members of an organization of nonpaid workers.

(B) Membership of a nonpaid worker in the organization shall be substantiated by adequate documentation in the files of the organization of nonpaid workers.

(C) A legally enforceable agreement between the nursing facility and the organization of nonpaid workers shall exist and establish the nursing facility's obligation to remunerate